



IDAHO DEPARTMENT OF
HEALTH & WELFARE



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January 9, 2009

Michael Andrus
Franklin County Medical Center Hospice
44 North First East
Preston, ID 83263

Provider #131519

Dear Mr. Andrus:

On **November 20, 2008**, a complaint survey was conducted at Franklin County Medical Center Hospice. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003678

Allegation #1: Patients were discharged even though they continued to have care needs.

Findings: An unannounced visit was made to the facility on 11/19/08. Staff was interviewed, policies were reviewed and eight clinical records were reviewed. These records included current as well as closed records and included patients who were discharged due to death as well as revocation of benefit.

One record documented a patient who was admitted on 9/18/07 with the diagnosis "left heart failure" and discharged on 6/27/08 with revocation of benefit. The patient experienced a stroke shortly after his admission. His condition then stabilized and remained stable for the next six months. Although the patient continued to require help with Activities of Daily Living, he was determined to not meet hospice care criteria by the hospice Interdisciplinary Team. The Franklin County Medical Center Hospice policy, titled "Discharge Criteria", was reviewed. It stated that one reason for discharging a patient was that "The IDT unitedly feel the patient no longer meets criteria for hospice." The patient and his wife were counseled about the discontinuation of hospice by staff on several occasions.

Documentation of this included, but was not limited to, a skilled nursing note, dated 5/13/08, that said "Spoke to spouse and patient about discontinuing hospice due to pt's stabilization", and 6/2/08 that said, "Social worker, spouse, patient and SN discussed hospice rules and regulations and the need to discontinue hospice services."

Seven additional records reviewed showed appropriate discharges of patients. Six discharges occurred due to death and one additional discharge occurred due to the patient no longer meeting hospice criteria.

It was determined that the hospice's decision to discharge the patient met hospice criteria.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Staff did not visit patients as ordered in the Plan of Care.

Findings: Eight clinical records were reviewed for appropriate staff visits according to the Plan of Care. One record documented a patient who was admitted to hospice services on 9/18/07. After a change in condition on 12/6/07, the patient's POC called for aide services twice a day. There were visit notes documenting these visits. Frequency was decreased to once a day from 12/15/08 until 2/29/08. There were visit notes documenting these daily visits. Frequency was decreased to three times a week from 3/3/08 until 6/27/08. There were documented visit notes for these visits.

Skilled nursing frequency was shown in the Plan of Care as one or two times a week. Although visits were not regularly made on the same day of the week, there were documented visit notes by skilled nursing at least once a week, occasionally more often, for all weeks while the patient was on hospice services.

Social worker visit frequency was entered on the Plan of Care for one or two times a month. There were social work visit notes documented for this frequency for all months while the patient was on hospice services.

Seven other records reviewed had documentation showing visits made to patients followed the frequency called for on the Plan of Care.

It was determined that staff did visit according to the Plan of Care.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Patients' families were not included in the Plan of Care.

Findings: Eight clinical records were reviewed. One record was of a patient who was admitted on 9/18/07 and discharged on 6/27/08. The patient's initial assessment was discussed with family as evidenced by spouse's signature on 9/18/07. The spouse regularly signed visit notes for all disciplines through the months of hospice care, indicating her inclusion in the patient's plan of care. The family requested an alternating pressure mattress on 1/18/08 which was supplied by hospice. A skilled nursing note, dated 12/7/07, stated that the wife would call hospice if she needed more help with the patient. A social service note, dated 4/22/08, said that both the patient and spouse were involved in pain management and felt pain was in control. A social worker note, dated 2/22/08, said that a new sling for the Hoyer lift was provided at the family's request and the spouse would let nursing know if the sling was working. All entries indicated that the family was included in the patient's Plan of Care.

Additionally, seven other records reviewed showed participation by families in the care planning process as evidenced by similar documentation.

It was determined that patients' families were included in the care planning process.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Patients were not given referrals at the time of discharge.

Findings: Eight clinical records were reviewed. One record documented a patient who was discharged from hospice services on 6/27/08 by revocation of benefit due to stabilization of condition. Documentation that the patient was given referrals to other health care services included: 1) A social worker visit note dated 6/2/08 that said options for further care within the community were given to the patient and family. 2) Social worker and skilled nursing notes dated 6/19/08 that said options were given for private aide, transitional care and family care. One entry further noted that the patient and family did not want the phone numbers of private paid caregivers and did not want Medicaid papers. 3) A social worker note dated 6/27/08 that said, "Again informed family members of long term care options." 4) A Case Conference report dated 6/24/08 in which skilled nursing noted, "Have offered options. Family refuses options." 5) A Case Conference note, dated 5/29/08, where skilled nursing stated that the spouse spoke to the facility secretary about different types of programs that may fit the patient and family needs.

Seven other records were reviewed. Six records were of patients who were discharged from the hospice due to death. One record reviewed was of a patient who was discharged due to not meeting hospice criteria.

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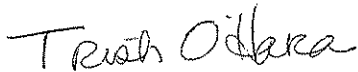
In this patient's case, appropriate referral to continuing care through community resources was documented.

It was determined that the agency did give the patient and his family referrals to other health care services prior to, and at the time of, the patient's discharge.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



TRISH O'HARA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care



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